

# **WORKERS' COMPENSATION**



## **MANUAL**

# **WORKERS' COMPENSATION MANUAL**

This Workers' Compensation Manual is for all Coordinators responsible for reporting workers' compensation claims and any information pertaining to these claims under the Commonwealth of Kentucky Workers' Compensation Self-Insurance Program. The manual is available online or by email. Every Coordinator should make sure all agency personnel working with workers' compensation has this manual available to comply with the WC Program procedures.

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# SECTION 1



## ADMINISTRATION

## **SECTION 1 – ADMINISTRATION**

### **WORKERS' COMPENSATION LAW**

The Workers' Compensation Law (KRS 342) is designed to compensate employees for loss of earning power due to work-related injuries or disease arising out of and in the course of their employment. This coverage includes:

- Medical
- Temporary Total Disability
- Permanent Partial Disability
- Permanent Total Disability
- Rehabilitation Services
- Death and Burial Benefits

NOTE: Refer to Section 2 for explanation of each type of benefit.

### **STATE WORKERS' COMPENSATION PROGRAM**

On July 1, 1979, the Commonwealth of Kentucky established a Workers' Compensation Self-Insurance Program to be administered by the Personnel Cabinet, Division of Employee Benefits. Claims are processed and reviewed by the State Workers' Compensation Deputy Executive Director along with their third party administrator.

Services provided by the Third Party Administrator include:

- Investigate all reported injuries to establish compensability.
- Payment of benefits.
- Establish loss-cost reserves.
- Arrange expert medical examinations.
- Return injured employees to gainful employment with RTW Program.
- Utilize Managed Care Plan for medical benefits.
- Contact Workers' Comp Deputy Executive Director for authorization of settlements.

# **ELIGIBILITY**

The Workers' Compensation Self-Insurance Program currently covers:

All State employees (except Transportation Cabinet)	
Kentucky Community and Technical College System	
Volunteer Firefighters	Pike County Clerk's Office
Volunteer Ambulance Personnel	Pike County Sheriff's Office
Kentucky Lottery Corporation	Warren County Clerk's Office
The Kentucky Center	Warren County Sheriff's Office
Lexington-Fayette County Health Department	Bluegrass Rape Crisis Center
Boone County Clerk's Office	Lincoln Trail Advocacy and Support Ctr
Boone County Sheriff's Office	Big Sandy Area Child Advocacy
Campbell County Clerk's Office	Lake Cumberland Children's Advocacy Ctr
Campbell County Sheriff's Office	
Christian County Clerk's Office	State University employees except:
Christian County Sheriff's Office	(University of Kentucky
Daviess County Clerk's Office	University of Louisville
Daviess County Sheriff's Office	Eastern Kentucky University
Hardin County Clerk's Office	Kentucky State University
Hardin County Sheriff's Office	Western Kentucky University
Fayette County Clerk's Office	Morehead University
Fayette County Sheriff's Office	Northern Kentucky University)
Jefferson County Clerk's Office	
Jefferson County Sheriff's Office	
Kenton County Clerk's Office	
Kenton County Sheriff's Office	
Madison County Clerk's Office	
Madison County Sheriff's Office	

# SECTION 2



## BENEFITS

## **SECTION 2 - BENEFITS**

### **MEDICAL**

An employee who sustains a **compensable** injury or disease is entitled to immediate and continuing medical treatment at the expense of the employer. An employee **should never** use their health insurance when they are seeking treatment under workers' compensation. The employer shall pay for the cure and relief from the effects of an injury or occupational disease as may reasonably be required at the time of the injury and thereafter during disability. This treatment includes:

- Medical
- Surgical and hospital treatment
- Nursing
- Medical supplies, surgical supplies and appliances

Requiring employees to make co-payments for treatment of work-related injuries is unlawful. Likewise, medical providers **may not** engage in "balance billing" by charging employees separately for amounts in excess of those set forth in the medical fee schedule.

### **TEMPORARY TOTAL DISABILITY BENEFITS**

An employee who sustains a compensable injury or disease and is unable to work after a waiting period of seven (7) days is entitled to income benefits which are calculated at:

- 66 2/3 percent of his average weekly wage, but no more than one hundred percent (100%), or less than twenty percent (20%) of the State's average weekly wage.

The weekly benefits for a 2005 injury are:

- Maximum \$607.23
- Minimum \$121.45

Maximum and minimum benefits are determined by the Workers' Compensation Board, and subject to change every year.

Entitlement to these benefits begins on the eighth (8th) day of disability. The first seven-(7) days of disability are payable only if total disability lasts 15 days or more. "Days of disability" refers to those days when a doctor has deemed an employee unable to work because of a work-related injury or disease. These "Days of Disability" do not refer only to consecutive scheduled workdays, but also includes weekends and holidays.

Temporary total disability benefits usually continue until an employee reaches maximum medical improvement, is released to return to work by a physician, or returns to work -- whichever occurs first.

## **PERMANENT PARTIAL DISABILITY**

An employee who has recovered as much as he/she will from an occupational injury or disease, but still has some permanent impairment which results in a permanent but partial loss of wages or wage earning capacity, is entitled to benefits calculated as follows:

- When an employee **does** return to work at an equal or greater wage, that employee will receive 66 2/3 percent of his/her average weekly wage, but not more than 75 percent of the State's average weekly wage, multiplied by his/her percentage of impairment caused by the injury or disease.

The weekly benefits for a 2006 injury are:

- Maximum \$473.42
- Minimum \$ None

Maximum and minimum benefits are determined by the Workers' Compensation Board and are subject to change every year.

## **PERMANENT TOTAL DISABILITY**

An employee who has reached maximum medical improvement but still has permanent impairment and restrictions, which prevent him from performing regular employment of the type he was doing before his injury, is entitled to benefits calculated at:

- 66 2/3 percent of his average weekly wage, but not more than one hundred percent (100%) or less than twenty percent (20%) of the State's average weekly wage.

The weekly benefits for a 2006 injury are:

- Maximum \$631.22
- Minimum \$126.24

Maximum and minimum benefits are determined by the Workers' Compensation Board, and subject to change every year.



## **DEATH AND BURIAL BENEFITS**

If death of employee occurs within four (4) years from date of injury as a direct result of the injury, a lump sum payment to estate will be made, from which burial expenses are to be paid.

## **WORKERS' COMPENSATION TEMPORARY TOTAL DISABILITY CHECKS**

According to 101 KAR 25:140 Section 4(2), the employee's absence due to illness or injury for which Workers' Compensation benefits are received for lost time, sick leave may be utilized to the extent of the difference between such benefits and the employee's regular salary.

Under no circumstances should an employee receive more pay than his normal salary for that period. The payroll officer is responsible to ensure that this does not occur. Upon receipt of the Workers' Compensation check, the payroll officer would determine if the employee was entitled to receive the check by the following guidelines:

1. If the employee utilized leave for the entire period, the Workers' Compensation check would be signed over to the State to reinstate leave. To determine the number of hours to reinstate, the payroll officer would divide the Workers' Compensation check by the employee's hourly wage rate and reinstate that number of hours to the employee's leave balance.
2. If the employee was placed on leave without pay for the entire period, the employee would be entitled to receive the entire Workers' Compensation check.
3. If the employee utilized leave and was also placed on leave without pay for a portion of the period, the Workers' Compensation check and the employee's payroll check would be added together to determine if the total would exceed the employee's normal salary.
  - a. If the two (2) checks do not exceed the employee's normal salary, the employee is entitled to receive both checks.
  - b. If the two (2) checks exceed the employee's normal salary, the amount in excess of the normal salary must be paid back to the State to reinstate leave. The amount in excess is divided by the employee's hourly wage to obtain the number of hours of leave to reinstate to the employee's leave balance.

## **REHABILITATION**

An employee who sustains an injury under Workers' Compensation shall be entitled to prompt medical rehabilitation services for whatever period of time necessary to accomplish physical rehabilitation goals, which are feasible, practical, and justifiable. If he is unable to perform work which he/she has previous training or experience, he shall be entitled to such vocational rehabilitation services, including retraining and job placement.

## **RTW PROGRAM**

The Personnel Cabinet's Workers' Compensation Branch has a Certified Rehabilitation Counselor to implement a RTW Program with all employees off on Temporary Total Disability. Responsibilities of the RTW Program include:

- Working with each agency covered under the Workers' Compensation Program in coordinating an early return to work for employees with a work-related injury designed to minimize loss time from work.
- Working with employers to modify the work environment to meet restrictions that are ordered from the doctors and to assist employers with providing modified duty.
- Coordinating rehabilitation nurses and claim adjusters to determine the extent of the restrictions, length of projected recovery and to work with employers to provide a successful return to modified duty and full duty work
- Work with the State Safety Director and Workers' Compensation Administrator to prevent injuries and to provide proactive management of workers' compensation claims.

It is extremely important that each agency make an extra effort to return injured workers to the job. In 1990, the Americans with Disabilities Act (ADA) was enacted and it is becoming more important than ever to meet the employee's restrictions and provide job modifications for employees with disabilities.

# **SECTION 3**



## **PROCEDURES FOR FILING FORMS**

## SECTION 3 - PROCEDURES AND FORMS

**EFFECTIVE 8/15/2005: CCMSI, Inc will be the third party administrator for the Commonwealth. CCMSI toll free number is 1-866-320-8456, Fax: 502-267-3046. The Commonwealth will begin utilizing a Managed Care Plan (MCP) 10/1/2005 per KRS 342-020, for workers' compensation medical benefits. This is a health care system that employs a network of "gatekeeper" physicians who provide referrals to specialists when needed. Injured employees must treat within the MCP with some exceptions for emergency care and may seek a second opinion "out-of-network" when surgery is recommended. Toll free number for Concentra/MCP is 1 866-320-8456. The employer is responsible for posting and distributing information regarding the MCP to their employees.**

### **FIRST REPORT OF INJURY OR ILLNESS (IA-1)**

For Workers' Compensation benefits, there is only one requirement of the employee--to "notify his/her supervisor as soon as practicable after happening thereof" (KRS 342-185). When a supervisor has knowledge of a work-related injury or illness or *alleged injury or illness* to one of his employees, it is his/her responsibility to obtain all pertinent information and complete a First Report of Injury (IA-1) form. Effective July 1, 2005 the Workers' Compensation Program will begin implementation of a new procedure for processing the First Report of Injury (IA-1). The supervisor responsible will be trained to enter the IA-1 online for submission directly to the Workers' Compensation Branch. Reporting will be accessible at any time. For employers that have limited internet access, the Workers' Compensation Branch call in line will continue to be available. The reporting time is Monday through Friday from 8:30 AM to 4:30 PM EST at either (502) 564-2226 or (502) 564-2307 or toll free at 1-888-860-0302. Any questions regarding the status of a Workers' Compensation claim should be addressed at (502) 564-6846. If the injury occurs during the evening hours or on the weekend the injury may be reported immediately online or at the beginning of the next working day. Copies of the IA-1 will be sent to your agency for documentation in your records. Even if the employee does not plan to visit a doctor, it is still important to report a First Report of Injury (IA-1). This must be completed "within three (3) working days", (KRS 342.038), after the injury due to the time requirement on making the first payment to the employee. This requirement cannot be met if the injury report is not received promptly. Failure to comply with this statute can result in a fine being levied of up to \$1,000.00 for each occurrence. The First Report of Injury (IA-1) must be submitted or called in by the supervisor immediately after notification of injury. The First Report of Injury (IA-1) must be complete and thorough. Give specifics: i.e., right arm or left arm, upper back or lower back, etc. Each question must be answered completely, accurately.

It is unlawful to knowingly make a misrepresentation of a material fact to obtain workers' compensation benefits. Likewise, it is unlawful to misrepresent important facts to avoid responsibility under the law. Through its Insurance Fraud Unit, the Department of Insurance actively investigates and prosecutes workers' compensation fraud. Violations may result in civil fines and criminal procedures.

For a copy of the First Report of Injury (IA-1) form, please see **Attachment A**.

### **First Report of Injury (IA-1) Signature Page**

All employees reporting a work related injury must sign this signature page when the submitted form is completed. By signing this page, employees acknowledge they understand it is unlawful to file a fraudulent workers' compensation claim.

## **MEDICAL WAIVER AND CONSENT FORM (FORM 106)**

Form 106 was adopted in April 1986 and must be completed by the employee and submitted along with the First Report of Injury (IA-1). This form allows workers' compensation to obtain medical documentation on the employee's injury. The employer is entitled to a signed release of medical information when an employee reports a work-related injury or disease. **Any medical bills received by the employer should be sent to the Workers' Compensation Program's third party administrator: CCMSI, Inc. P O Box 43909 Louisville Kentucky 40253, 1 866-320-8456.**

Form 106 was recently revised in April 2003, to assist health care providers to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPPA). For a copy of the Medical Waiver and Consent Form please see **Attachment B**.

## **WORKERS' COMPENSATION TEMPORARY PRESCRIPTION SERVICES ID FORM –**

May be given to injured employees at time of injury to fill related prescriptions. This form **MUST BE PRESENTED** to your pharmacist when you fill your initial prescription(s). **ATTACHMENT C**.

## **LOSS TIME AND RETURN TO WORK FORM**

Form WCF-1 must be completed by the supervisor and submitted **immediately** when one of the following occurs in order for employees to receive their lost time benefits in a timely manner:

- When an injured employee loses time from work due to a work-related injury.
- When an injured employee returns to work.
- At the time of death of an injured employee.

For a copy of the Loss Time and Return to Work Form (WCF-1), please see **Attachment D**.

## **SICK LEAVE - WORKERS' COMPENSATION FORM**

According to 101 KAR 2:140 Section 4 (2), the employee's absence due to illness or injury for which Workers' Compensation benefits are received for lost time, sick leave may be utilized to the extent of the difference between such benefits and the employee's regular salary.

To use sick leave for a Workers' Compensation injury, the employee must assign his/her Workers' Compensation check to the agency by completing a Sick Leave - Workers' Compensation form prior to receiving sick leave. This form **must be signed** by the employee, witnessed, and forwarded to the payroll officer for their records. For a copy of the Sick Leave - Workers' Compensation Form (WCF-2), please see **Attachment E**.

## **REPORT OF MEDICAL STATUS FORM**

The Report of Medical Status Form (WCF-5) was adopted by the Workers' Compensation Office in October 1994 and should be issued at the time the First Report of Injury (IA-1) is completed or as soon as practicable, if the employee intends to seek medical treatment. This form must be issued to the employee prior to their first doctor's appointment. The employer is responsible for completing the first section of the form titled, "To Be Completed By Employer". The physician will then complete the remaining sections of the form and return it to the employee. Once the physician has completed the form, the employee should return the completed form to their employer. **The employer will then mail the completed form to the Workers' Compensation Office.** It is imperative that each injured employee receive this form **before** they go to the doctor's office. With the proper completion of this form, this office can better monitor the treatment of each injured employee. For a copy of the Report of Medical Status Form (WCF-5), please see **Attachment F**.

**REIMBURSEMENT FORM** - For a copy of the Request for Payment For Services or Reimbursement Form 114, please see **Attachment G**.

**AVERAGE WEEKLY WAGE FORM** – This form should be completed by the employer when requested and **includes all paid leave**. In most instances, an employee's AWW is calculated by using the highest wages paid during a 13 week period in the year before the injury occurred. If the employee has not worked 52 weeks, a "like employee's" wages should be used. Overtime is included, but only at the regular hourly wages. These earnings for the highest quarter are then divided by 13 and the result is the employee's AWW. Questions regarding this form should be forwarded to the Workers' Compensation Branch. For a copy of the Weekly Wage Form, please see **Attachment H**

## COMMONWEALTH OF KENTUCKY WORKERS' COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' compensation Act (KRS Chapter 342).  
Conspicuous posting of the Notice is required by law. Effective 7/1/2005:

Employer Name: Commonwealth of Kentucky  
Address: 200 Fair Oaks Lane, Room 511  
Frankfort, KY 40601

Workers Compensation TPA: CCMSI, Inc.  
Policy Number: Self-Insured  
Address: P O Box 43909  
Louisville, KY 40253

Telephone: (866) 320-8456  
Contact Person: Mary Carney

**EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a Form 113 will be furnished by your employer or its insurance carrier for this purpose.**

**This employer is participating in a Managed Care Plan for medical care effective 8/1/2005. For information regarding participating physicians call 1-866-320-8456.**

**DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) days of disability. A CLAIM MUST BE filed with the Department of Workers Claim WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits for continuing benefits.**

**NEED ASSISTANCE? Contact your employer's claim representative or Workers' Compensation Branch, Personnel Cabinet at 1-502-564-6847. If your question about workers' compensation is not resolved, call THE KENTUCKY DEPARTMENT OF WORKERS' CLAIMS AT 1-800-554-8601 to speak to an Ombudsman or Workers Compensation Specialist.**

**EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT A TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.**

AN EQUAL OPPORTUNITY EMPLOYER M F D

**IA-1 WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS**

EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER/ADMINISTRATOR CLAIM NUMBER N/A				REPORT PURPOSE CODE N/A			
				JURISDICTION N/A		JURISDICTION CLAIM NUMBER N/A					
				INSURED REPORT NUMBER N/A							
				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION # N/A			
SIC CODE N/A		EMPLOYER FEIN N/A						PHONE#			
CARRIER/CLAIMS ADMINISTRATOR CARRIER (NAME, ADDRESS & PHONE NO.)  N/A				POLICY PERIOD N/A TO		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)  N/A					
				CHECK IF APPROPRIATE							
				<input type="checkbox"/> SELF INSURANCE							
CARRIER FEIN N/A		POLICY/SELF-INSURED NUMBER N/A				ADMINISTRATOR FEIN N/A					
AGENT NAME & CODE NUMBER N/A											
EMPLOYEE/WAGE											
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE	
ADDRESS (INCL ZIP)				SEX		MARITAL STATUS		OCCUPATION/JOB TITLE			
				M MALE F FEMALE U UNKNOWN		U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN		EMPLOYMENT STATUS			
				# OF DEPENDENTS				NCCI CLASS CODE N/A			
PHONE											
RATE		PER: DAY MONTH		WEEK OTHER:		#DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES NO	
								DID SALARY CONTINUE?		YES NO	
OCCURRENCE/TREATMENT											
TIME EMPLOYEE BEGAN WORK		AM PM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		AM PM		LAST WORK DATE	
										DATE EMPLOYER NOTIFIED	
										DATE DISABILITY BEGAN	
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED			
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE			
<input type="checkbox"/> YES <input type="checkbox"/> NO				N/A				N/A			
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL										CAUSE OF INJURY CODE N/A	
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				YES NO			
				WERE THEY USED?				YES NO			
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL (NAME & ADDRESS)				INITIAL TREATMENT			
								0 NO MEDICAL TREATMENT			
								1 MINOR: BY EMPLOYER			
								2 MINOR CLINIC/HOSP			
								3 EMERGENCY CARE			
								4 HOSPITALIZED > 24 HRS			
								5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED			
WITNESSES (NAME & PHONE #)											
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER			



**Applicable in Arkansas**

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding worker's compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D Felony.

**Applicable in California**

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payment is guilty of a felony.

**Applicable in Connecticut**

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

**Applicable in California**

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

**Applicable in Delaware and Oklahoma**

Any person who, knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section.

\*Delaware Statutes Regulation: Del #C Section 913(B)

**Applicable in Florida**

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self-insured program, files any statement of claim containing any false or misleading information is guilty of a felony of the third degree.

**Applicable in Idaho**

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**Applicable in Indiana**

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Applicable in Kentucky and New York**

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Applicable in Michigan**

Any person who knowingly and with intent to injure or defraud any insurer submits a claim containing any false, incomplete, or misleading information shall, upon conviction, be subject to imprisonment for up to one year for a misdemeanor conviction or up to ten years for a felony conviction and payment of a fine of up to \$5,000.00.

**Applicable in Minnesota**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Applicable in Nevada**

Pursuant to NRS 686A.291, any person who knowingly and willfully files as statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

**Applicable in New Hampshire**

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

**Applicable in New Jersey**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Applicable in Ohio**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Applicable in Pennsylvania**

Any person who knowingly and with intent to injure or defraud any insurer files a claim containing any false, incomplete or misleading information shall upon conviction, be subject to imprisonment for up to seven years or payment of a fine of up to \$50,000.

**Applicable in Utah**

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

**EMPLOYEE SIGNATURE:** \_\_\_\_\_

**COMMONWEALTH OF KENTUCKY  
OFFICE OF WORKERS' CLAIMS  
657 CHAMBERLIN AVENUE  
FRANKFORT, KY 40601**

**MEDICAL WAIVER AND CONSENT**

I, \_\_\_\_\_, having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my work-related injury occurring on or about \_\_\_\_\_ any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other conditions related to the same body part. Such information is being disclosed to the purpose of facilitating my claim for Kentucky workers' compensation benefits. I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of the workers' compensation claim. I understand that no medical provider may condition treatment or payment on whether I sign this medical waiver; however, I further understand that failure to sign this medical waiver may result in suspension or delay of the workers' compensation claim. I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient. This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Signed at \_\_\_\_\_, Kentucky, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient Or Personal Representative

Social Security Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Description Of Personal Representative's Authority

**KENTUCKY WORKERS' COMPENSATION AND HIPAA**

On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will take effect. This regulation limits the situations in which medical providers may release patient information, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosures for workers' compensation are in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation..."

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires for disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). Kentucky law further states that once this Form 106 is signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers fund, or the administrative law judge, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once the Form 106 is signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Department of Workers' Claims at 800 554-8601.

## Workers' Compensation Temporary Prescription Services ID Important Information

### ATTENTION INJURED WORKER

This Workers' Compensation Temporary Prescription Services ID form **MUST BE PRESENTED** to your pharmacist when you fill your initial prescription(s). If you have questions or need to locate a participating pharmacy, please contact Express Scripts Customer Service at 866-576-3864.

### ATENCIÓN: TRABAJADOR LESIONADO

Este formulario de Identificación para Servicios Temporales de Prescripción de Recetas por Compensación del Trabajador **DEBERÁ SER PRESENTADO** a su farmacéutico al surtir su(s) receta(s) inicial(es). Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 866-576-3864.

<p><b>CCMSI</b></p> <p>Attention Supervisor: 9 digit SSN#, pre-printed group number and date of birth must be completed.</p> <p>ID # _____ Injured Workers' Claim ID</p> <p>DATE OF INJURY --/--/---- MM/DD/ CCYY</p> <p>GROUP # <b>COMP MC</b></p> <p>EMPLOYEE DATE OF BIRTH --/--/----</p>	<p>EMPLOYEE NAME</p> <table border="1"> <tr> <td>FIRST</td> <td>MI</td> <td>LAST</td> </tr> </table> <p>MAILING ADDRESS STREET</p> <p>CITY STATE ZIP</p> <p>EMPLOYER'S NAME Personnel Cabinet Work Comp Program</p> <p>DEPARTMENT _____</p> <p><i>Help Desk: This is a POS program through Express Scripts only. For assistance call the Express Scripts Help Desk at 866-576-3864.</i></p>	FIRST	MI	LAST
FIRST	MI	LAST		

### Attention Pharmacist:

StrataCare Workers' Compensation prescription program is administered by Express Scripts. The following are the steps necessary to submit a claim for comp mc injured workers.

Please follow the action steps listed below to enter the claim. Be sure you are using NCPDP version 3.2 allowing for faster service.

Step 1	Enter Bin Number 003858
Step 2	Enter Processor Control A4
Step 3	Enter the Group Number as it appears above
Step 4	Enter the injured worker's 9 digit SSN#
Step 5	Enter first name & last name
Step 6	Enter the injured worker's date of birth as it appears above

PHARMACY, NEED  
ASSISTANCE?

If you have any questions while processing the claim, please call the Express Scripts Help Desk at 866-576-3864.



MEMORANDUM

TO: PERSONNEL CABINET  
Return-To-Work Program  
Room 511, 200 Fair Oaks Lane  
Frankfort, Kentucky 40601  
502-564-0348  
(FAX) 502-564-3524

CONTACT NAME: \_\_\_\_\_  
AGENCY: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_

SUBJECT: Lost Time and Return to Work Form

DATE: \_\_\_\_\_

.....  
This form must be completed by the supervisor and submitted immediately when one of the following occurs:

- 1) When an injured employee begins to lose a full day from work due to a work-related injury.
- 2) When an injured employee returns to modified duty **OR** full duty work. (This information is important in order to assure that an employee is not over paid.)
- 3) At the time of death of an injured employee.

.....  
NAME OF INJURED \_\_\_\_\_  
(FIRST) (MI) (LAST)

DATE OF INJURY \_\_\_\_\_

DATE LOSS OF WORK BEGAN \_\_\_\_\_

DATE INJURED RETURNED TO MODIFIED DUTY WORK \_\_\_\_\_

DATE INJURED RETURNED TO FULL DUTY WORK \_\_\_\_\_

COMMENTS: (Notify if death of employee, Employee returned to work with restrictions, returned to only part-time work, returned at different job, etc.)

COMPLETED BY: \_\_\_\_\_ OFFICAL TITLE \_\_\_\_\_

**SICK LEAVE - WORKERS' COMPENSATION**

**NAME:** \_\_\_\_\_

I hereby request payment from my accumulated sick leave while I am off work due to an illness or injury for which workers' compensation benefits are claimed.

I acknowledge that I am not entitled to use sick leave for time off from work due to an illness or an injury for which workers' compensation benefits are claimed except to supplement my workers' compensation benefits and maintain my regular full salary.

I hereby assign my workers' compensation benefits to: (State Agency)  
and authorize said agency to receive and hold by workers' compensation check until I endorse said check to the agency.

I may revoke this authority at any time in writing by delivering a copy of the writing to the agency, however, said revocation shall not apply to any workers' compensation check for periods of time in which I have already received sick pay.

This the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

[illegible]

**Form 114****KENTUCKY OFFICE OF WORKERS CLAIMS**657 Chamberlin Ave  
Frankfort, Kentucky 40601**REQUEST FOR PAYMENT FOR SERVICES OR REIMBURSEMENT**  
**FOR COMPENSABLE EXPENSES**

TO BE FILED WITH THE RESPONSIBLE EMPLOYER OR ITS PAYMENT OBLIGOR

1) Name, address and Workers Compensation claim number of Employee for whom services were provided or expense incurred: \_\_\_\_\_  
\_\_\_\_\_

2) Specific type and dates of service(s) provided:

<b>Dates:</b>	<b>Type of Service(s)</b>
_____	_____
_____	_____
_____	_____
_____	_____

3) Name and address of physician who ordered services: (include written authorization if available)  
\_\_\_\_\_4) Reasonable value of services, including method of computation: \$ \_\_\_\_\_ : \_\_\_\_\_  
\_\_\_\_\_

5) Other expenses incurred for cure or relief of a work injury or occupational disease(s):

<b>Dates:</b>	<b>Description of Expense(s)</b>	<b>\$ Amount</b>	<b>If mileage, number of miles</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
<b>Total</b>		<b>\$</b>	<b>Miles:</b>

Please attach receipts for all purchased items

**Certification:**

I hereby certify that the above services were performed or expenses were incurred for the cure or relief of a work injury or occupational disease sustained by the above employee.

Witness: \_\_\_\_\_

\_\_\_\_\_  
(Name of Person requesting payment)

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone no: \_\_\_\_\_

**NOTICE:**

Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

KENTUCKY  
DEPARTMENT OF WORKERS CLAIMS

CLAIM NUMBER \_\_\_\_\_

\_\_\_\_\_

PLAINTIFF

VS

WAGE CERTIFICATION

\_\_\_\_\_

DEFENDANTS

- 
1. Date of Injury/Exposure as reported on Form 101/102/103: \_\_\_\_\_
  2. Method of Wage Payment (check one):

<input type="checkbox"/> Hourly	<input type="checkbox"/> Daily
<input type="checkbox"/> Weekly Salary	<input type="checkbox"/> Monthly Salary
<input type="checkbox"/> Yearly Salary	<input type="checkbox"/> Output of Employee
  3. Date of Hire or Employment: \_\_\_\_\_
  4. Status or Classification of Employment (check one):

<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	<input type="checkbox"/> Probationary
<input type="checkbox"/> Seasonal	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Apprentice/Trainee
  5. Did Employer provide any of the following (check appropriate ones):

<input type="checkbox"/> Board	<input type="checkbox"/> Rent	<input type="checkbox"/> Housing
<input type="checkbox"/> Lodging	<input type="checkbox"/> Fuel	
  6. Did Employee (check appropriate ones):

<input type="checkbox"/> Work Overtime	<input type="checkbox"/> Receive Gratuities	<input type="checkbox"/> Paid Vacations/Holidays
--	---	--



Claimant's Name: \_\_\_\_\_

ATTACHMENT H-1

Claim Number: \_\_\_\_\_

Weeks Worked Month/Day/Year	# of Regular Hours Worked		# of Overtime Hours Worked	Regular Hourly Rate		Weekly Wage
1.	_____	+	_____	X _____	=	_____
2.	_____	+	_____	X _____	=	_____
3.	_____	+	_____	X _____	=	_____
4.	_____	+	_____	X _____	=	_____
5.	_____	+	_____	X _____	=	_____
6.	_____	+	_____	X _____	=	_____
7.	_____	+	_____	X _____	=	_____
8.	_____	+	_____	X _____	=	_____
9.	_____	+	_____	X _____	=	_____
10.	_____	+	_____	X _____	=	_____
11.	_____	+	_____	X _____	=	_____
12.	_____	+	_____	X _____	=	_____
13.	_____	+	_____	X _____	=	_____
				Total:		\$ _____
				÷ By 13 weeks		
				=		\$ _____
14.	_____	+	_____	X _____	=	_____
15.	_____	+	_____	X _____	=	_____
16.	_____	+	_____	X _____	=	_____
17.	_____	+	_____	X _____	=	_____
18.	_____	+	_____	X _____	=	_____
19.	_____	+	_____	X _____	=	_____
20.	_____	+	_____	X _____	=	_____
21.	_____	+	_____	X _____	=	_____
22.	_____	+	_____	X _____	=	_____
23.	_____	+	_____	X _____	=	_____
24.	_____	+	_____	X _____	=	_____
25.	_____	+	_____	X _____	=	_____
26.	_____	+	_____	X _____	=	_____
				Total:		\$ _____
				÷ By 13 weeks		
				=		\$ _____

Claimant's Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Weeks Worked Month/Day/Year	# of Regular Hours Worked		# of Overtime Hours Worked	Regular Hourly Rate		Weekly Wage
27.	_____	+	_____	x _____	=	_____
28.	_____	+	_____	x _____	=	_____
29.	_____	+	_____	x _____	=	_____
30.	_____	+	_____	x _____	=	_____
31.	_____	+	_____	x _____	=	_____
32.	_____	+	_____	x _____	=	_____
33.	_____	+	_____	x _____	=	_____
34.	_____	+	_____	x _____	=	_____
35.	_____	+	_____	x _____	=	_____
36.	_____	+	_____	x _____	=	_____
37.	_____	+	_____	x _____	=	_____
38.	_____	+	_____	x _____	=	_____
39.	_____	+	_____	x _____	=	_____
				Total:		\$ _____
				÷ By 13 weeks		
				=		\$ _____
40.	_____	+	_____	x _____	=	_____
41.	_____	+	_____	x _____	=	_____
42.	_____	+	_____	x _____	=	_____
43.	_____	+	_____	x _____	=	_____
44.	_____	+	_____	x _____	=	_____
45.	_____	+	_____	x _____	=	_____
46.	_____	+	_____	x _____	=	_____
47.	_____	+	_____	x _____	=	_____
48.	_____	+	_____	x _____	=	_____
49.	_____	+	_____	x _____	=	_____
50.	_____	+	_____	x _____	=	_____
51.	_____	+	_____	x _____	=	_____
52.	_____	+	_____	x _____	=	_____
				Total:		\$ _____
				÷ By 13 weeks		
				=		\$ _____

**CERTIFICATION**

I hereby certify that the above wage information is a true and accurate accounting of the wages of (claimant's name) \_\_\_\_\_ from the date of employment or fifty-two weeks prior to the date of the injury/last exposure as set forth in the Form 101/102/103, whichever is shorter.

\_\_\_\_\_  
Name of Company

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**CERTIFICATE**

It is hereby certified that the original of this wage certification was mailed this \_\_\_\_\_ day of \_\_\_\_\_, 199\_\_ to the Commissioner and a copy of the same to Counsel of record and the assigned Administrative Law Judge.

\_\_\_\_\_  
Attorney for Defendant Employer

# APPENDIX



# DEFINITIONS

COMPENSABLE	Entitlement to benefits
COMPENSATION	Payment to injured worker or his/her dependents
DISABILITY	A decrease of wage earning capacity due to injury or loss of ability to compete to obtain the kind of work the employee is customarily able to do.
TEMPORARY TOTAL DISABILITY	Means the condition of an employee who has not reached <i>maximum medical improvement</i> from an injury and has not reached a level of improvement that would permit a return to employment.
INCOME BENEFITS	Payments made to the disabled worker or his dependents in case of death, excluding medical and related benefits.
INJURY	"Injury" means any work-related traumatic event or series of traumatic events including cumulative trauma, arising out of and in the course of employment which is the proximate cause producing a harmful change in the human organism evidenced by objective medical findings. "Injury" does not include the effects of the natural aging process, and does not include any communicable disease unless the risk of contracting the disease is increased by the nature of the employment. "Injury" when used generally, unless the context indicates otherwise, shall include an occupational disease and damage to a prosthetic appliance, but shall not include a psychological, psychiatric, or stress-related change in the human organism, unless it is a direct result of a physical injury.
OCCUPATIONAL DISEASE	Means a <u>disease</u> arising out of and in the course of the employment.
MEDICAL RELATED BENEFITS	Payments made for medical, hospital, burial and other services other than income benefits.
MEDICAL SERVICES	Medical, surgical, dental, hospital, nursing and medical rehabilitation services, medicines, and fittings for artificial or prosthetic devices
SELF-INSURER	An employer who has been authorized to carry his own liability on his employees.